Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICAINS AND SURGEONS
4780 NORTH JOSEY LANE
CARROLLTON TX 75010

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-1530-01

MFDR Date Received
JANUARY 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The office visit was denied stating that the documentation does not support the services rendered. I have attached the office visit notes and it does support 2 of the 3 components that are necessary to bill a 99205 office visit."

Amount in Dispute: $304.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99205 requires two of three components – comprehensive history, comprehensive exam, and/or medical decision-making of high complexity. However, the documentation in the DWC-60 packet reveals a straight forward exam and straight forward decision-making. It meets the components of 99201. Further, the requestor states he was not paid for the x-ray mentioned above. Payment was made. (Attachment 2) For this reason no payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 6, 2011	CPT Code 99205	$415.00	$0.00
	CPT Code 72050-26	$23.61	$0.00
TOTAL		$304.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-150-Payer deems the information submitted does not support this level of service.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code of NCPDP reject reason code.)
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 890-Denied per AMA CPT code description for level of service and/or nature of presenting problems.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891-No additional payment after reconsideration.

Issues

1. Does the submitted documentation support billed service for CPT code 99205? Is the requestor entitled to reimbursement?
2. Is the requestor entitled to reimbursement for CPT code 72050-26?

Findings

1. According to the explanation of benefits, the respondent initially denied reimbursement for CPT code 99205 based upon reason codes "CAC-150, CAC-16, 225, and 890."

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 99205 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family."

   The requestor states "I have attached the office visit notes and it does support 2 of the 3 components that are necessary to bill a 99205 office visit."

   A review of the submitted report finds that the requestor did not meet the documentation requirements for billing CPT code 99205, specifically a comprehensive history, a comprehensive examination and medical decision of high complexity. The requestor notes that the office visit note supports 2 of the 3 components; however, CPT code 99205 requires documentation of all three (3) key components. Therefore, the respondent's denial based upon reason codes "CAC-150, CAC-16, 225, and 890" are supported. As a result, reimbursement is not recommended.

2. The respondent states in the position summary that CPT code 72050-26 was paid. In support of their position, a copy of check number 10671822 was submitted that indicates $25.12 was paid on June 17, 2011. The Division finds that payment has been issued for CPT code 72050-26, and additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/23/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.